

court to award interest in favor of the prevailing party on any amount due as a result of the court's decision. If the intermediary withheld any portion of the amount in controversy prior to the date the provider seeks judicial review by a Federal court, and the Medicare program is the prevailing party, interest is payable by the provider only on the amount not withheld. Similarly, if the Medicare program seeks to recover amounts previously paid to a provider, and the provider is the prevailing party, interest on the amounts previously paid to a provider is not payable by the Medicare program since that amount had been paid and is not due the provider.

(3) *Rate.* The amount of interest to be paid is equal to the rate of return on equity capital (see § 413.157) in effect for the month in which the civil action is commenced.

Example: An intermediary made a final determination on the amount of Medicare program reimbursement on June 15, 1974, and the provider appealed that determination to the Provider Reimbursement Review Board. The Board heard the appeal and rendered a decision adverse to the provider. On October 28, 1974, the provider commenced civil action to have such decision reviewed. The rate of return on equity capital for the month of October 1974 was 11.625 percent. The period for which interest is computed begins on January 1, 1975, and the interest beginning January 1, 1975, would be at the rate of 11.625 percent per annum.

[51 FR 34793, Sept. 30, 1986, as amended at 51 FR 42238, Nov. 24, 1986; 53 FR 1628, Jan. 21, 1988; 57 FR 39830, Sept. 1, 1992; 59 FR 36713, July 19, 1994; 64 FR 41682, July 30, 1999; 65 FR 41211, July 3, 2000]

EFFECTIVE DATE NOTE: At 66 FR 41394, Aug. 7, 2001, § 413.64 was amended by revising paragraph (h)(2)(i), effective Jan. 1, 2002. For the convenience of the user, the revised text is set forth as follows.

§ 413.64 Payment to providers: Specific rules.

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(h) *Periodic interim payment method of reimbursement—* * * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, described in § 412.1(a)(1) of this chapter, under subpart B of part 412 of this chapter or are paid under

the prospective payment system described in subpart P of part 412 of this chapter.

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§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions.* (1) *Scope.* This section applies to all facilities or organizations for which provider-based status is sought, including remote locations of hospitals, as defined in paragraph (a)(2) of this section and satellite facilities as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter, other than ESRD facilities. Determinations for ESRD facilities are made under § 413.174 of this chapter.

(2) *Definitions.* In this subpart E, unless the context indicates otherwise—

Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

Department of a provider means a facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider may not be licensed to provide health care services in its own right, may not by itself be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term "department of a provider" does not include an RHC or, except as specified in paragraph (m)(1) of this section, an FQHC.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital,

satellite facility, or a provider-based entity.

Main provider means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider of health care services, or an RHC or an FQHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.

Remote location of a hospital means a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital may not be licensed to provide inpatient hospital services in its own right, and Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term “remote location of a hospital” does not include a satellite facility as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter.

(b) *Responsibility for obtaining provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

(2) A main provider or a facility or organization must contact CMS and the facility or organization must be determined by CMS to be provider-based before the main provider bills for services of the facility or organization as if

the facility or organization were provider-based, or before it includes costs of those services on its cost report.

(3) A facility that is not located on the campus of a hospital and is used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a free-standing facility, unless it is determined by CMS to have provider-based status.

(c) *Reporting.* (1) A main provider that creates or acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to CMS if the facility or organization is located off the campus of the provider, or inclusion of the costs of the facility or organization in the provider’s cost report would increase the total costs on the provider’s cost report by at least 5 percent, and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status.

(2) A main provider that has had one or more facilities or organizations considered provider-based also must report to CMS any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization.

(d) *Requirements.* An entity must meet all of the following requirements to be determined by CMS to have provider-based status.

(1) *Licensure.* The department of the provider, remote location of a hospital, or satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, remote location of a hospital, or satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, remote location of a hospital, or satellite facility under a single license.

If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, CMS will determine that the facility or organization does not have provider-based status.

(2) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.

(ii) The main provider and the facility or organization seeking status as a department of the provider, remote location of a hospital, or satellite facility have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.

(iv) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits/code of conduct), and final approval for medical staff appointments in the facility or organization.

(3) *Administration and supervision.* The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments, as evidenced by compliance with all of the following requirements:

(i) The facility or organization is under the direct supervision of the main provider.

(ii) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision

and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(A) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its departments; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(A) Contracted out under the same contract agreement; or

(B) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

(4) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the Chief Medical Officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the Chief Medical Officer or other similar official of the main provider, and is under the

same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(5) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of the facility or organization are reported in a cost center of the provider, and the financial status of the facility or organization is incorporated and readily identified in the main provider's trial balance.

(6) *Public awareness.* The facility or organization seeking status as a department of a provider, remote location of a hospital, or satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(7) *Location in immediate vicinity.* The facility or organization and the main provider are located on the same campus, except where the following requirements are met:

(i) The facility or organization demonstrates a high level of integration with the main provider by showing

that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(C) If the facility or organization is unable to meet the criteria in paragraph (d)(7)(i)(A) or (d)(7)(i)(B) of this section because it was not in operation during all of the 12-month period described in the previous sentence, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the main provider.

(ii) A facility or organization is not considered to be in the "immediate vicinity" of the main provider unless the facility or organization and the main provider are located in the same State or, where consistent with the laws of both States, adjacent States.

(iii) A rural health clinic that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in § 412.62(f)(1)(iii) of this chapter, and has fewer than 50 beds, as determined under § 412.105(b) of this chapter, is not subject to the criterion in this paragraph (d)(7)(i).

(e) *Provider-based status not applicable to joint ventures.* A facility or organization cannot be considered provider-based if the entity is owned by two or more providers engaged in a joint venture. For example, where a hospital has jointly purchased or jointly created

free-standing facilities under joint venture arrangements, neither party to the joint venture arrangement can claim the free-standing facility as a provider-based entity.

(f) *Management contracts.* Facilities and organizations that otherwise meet the requirements of paragraph (d) of this section, but are operated under management contracts, must also meet all of the following criteria:

(1) The staff of the facility or organization, other than management staff, are employed by the provider or by another organization, other than the management company, which also employs the staff of the main provider.

(2) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph (d)(3)(iii) of this section.

(3) The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph (d)(3)(ii) of this section.

(4) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

(g) *Obligations of hospital outpatient departments and hospital-based entities.*

(1) Hospital outpatient departments located either on or off the campus of the hospital that is the main provider must comply with the anti-dumping rules in §§ 489.20(l), (m), (q), and (r) and § 489.24 of this chapter. If any individual comes to any hospital-based entity (including an RHC) located on the main hospital campus, and a request is made on the individual's behalf for examination or treatment of a medical condition, as described in § 489.24 of this chapter, the hospital must comply with the anti-dumping rules in § 489.24 of this chapter.

(2) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied.

(3) Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

(4) Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with the non-discrimination provisions in § 489.10(b) of this chapter.

(5) Hospital outpatient departments (other than RHCs) must treat all Medicare patients, for billing purposes, as hospital outpatients. The department must not treat some Medicare patients as hospital outpatients and others as physician office patients.

(6) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at § 412.2(c)(5) of this chapter and at § 413.40(c)(2), respectively.

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital has a duty to provide written notice to the beneficiary, prior to the delivery of services, of the amount of the beneficiary's potential financial liability (that is, of the fact that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand. If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, prior to the delivery of services, to the beneficiary's authorized representative.

(8) Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

(h) *Furnishing all services under arrangement.* A facility or organization

may not qualify for provider-based status if all patient care services furnished at the facility are furnished under arrangement.

(i) *Inappropriate treatment of a facility or organization as provider-based.* (1) *Determination and review.* If CMS learns that a provider has treated a facility or organization as provider-based and the provider had not obtained a determination of provider-based status under this section, CMS will—

(i) Review current payments and, if necessary, take action in accordance with the rules on inappropriate billing in paragraph (j) of this section;

(ii) Investigate and determine whether the requirements in paragraph (d) of this section (or, for periods prior to October 10, 2000, the requirements in applicable program instructions) were met; and

(iii) Review all previous payments to that provider for all cost reporting periods subject to re-opening in accordance with §405.1885 and §405.1889 of this chapter.

(2) *Recovery of overpayments.* If CMS finds that payments for services at the facility or organization have been made as if the facility or organization were provider-based, even though CMS had not previously determined that the facility or organization qualified for provider-based status, CMS will recover the difference between the amount of payments that actually were made and the amount of payments that CMS estimates should have been made in the absence of a determination of provider-based status. Recovery will not be made for any main provider cost reporting periods beginning before January 10, 2001 or, in the case of a facility organization paid as a provider-based entity, for that entity's cost reporting periods beginning before January 10, 2001 if, during all of those periods, the management of the facility or organization made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (h)(3) of this section.

(3) *Exception for good faith effort.* CMS determines that the management of a facility or organization has made a good faith effort to operate it as a provider-based entity if—

(i) The requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(6) of this section are met;

(ii) All facility services were billed as if they had been furnished by a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity of the main provider; and

(iii) All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(2) of this section.

(j) *Inappropriate billing.* If CMS finds that a facility or organization is being treated as provider-based without having obtained a determination of provider-based status under this section, CMS will notify the provider, adjust future payments, review previous payments, determine whether the facility or organization qualifies for provider-based status under this paragraph, and continue payments only under specific conditions, as described in paragraphs (j)(1), (j)(2), (j)(3), and (j)(4) of this section.

(1) *Notice to provider.* If CMS finds that inappropriate billing has occurred or is occurring since no provider-based determination has been made by CMS, CMS will issue written notice to the provider that payments for past cost reporting periods may be reviewed and recovered as described in paragraph (i) of this section, that future payments for services in or of the facility or organization will be adjusted as described in paragraph (j)(2) of this section, and that a determination of provider-based status will be made.

(2) *Adjustment of payments.* If CMS finds that inappropriate billing has occurred or is occurring since no provider-based determination has been made by CMS, CMS will adjust future payments to the provider, the facility or organization, or both, to approximate as closely as possible the amounts that would be paid, in the absence of a provider-based determination, if all other requirements for billing were met.

(3) *Review of previous payments.* If CMS finds that inappropriate billing has occurred or is occurring since no provider-based determination has been

made by CMS, CMS will review previous payments and, if necessary, take action in accordance with the rules on inappropriate treatment of a facility or organization as provider-based in paragraph (i) of this section.

(4) *Determination regarding provider-based status.* If CMS finds that inappropriate billing has occurred or is occurring since no provider-based determination has been made by CMS, CMS will determine whether the facility or organization qualifies for provider-based status under the criteria in this section. If CMS determines that the facility or organization qualifies for provider-based status, future payment for services at or by the facility or organization will be adjusted to reflect that determination. If CMS determines that the facility or organization does not qualify for provider-based status, future payment for services at or by the facility or organization will be made only in accordance with the rules in paragraph (j)(5) of this section.

(5) *Continuation of payment.* The notice of denial of provider-based status sent to the provider will ask the provider to notify CMS in writing, within 30 days of the date the notice is issued, of whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a free-standing facility. If the provider indicates that the facility, organization, or practitioners will not be seeking to enroll, or if CMS does not receive a response within 30 days of the date the notice was issued, all payment under this paragraph (j)(5) will end as of the 30th day after the date of notice. If the provider indicates that the facility or organization, or its practitioners, will be seeking to meet enrollment and other requirements for billing for services in a free-standing facility, payment for services of the facility or organization will continue, at the adjusted amounts described in paragraph (j)(2) of this section for as long as is required for all billing requirements to be met (but not longer than 6 months) if the facility or organization, or its practitioners, submit a complete enrollment application and provide all other required information within 90

days after the date of notice; and the facility or organization, or its practitioners, furnish all other information needed by CMS to process the enrollment application and verify that other billing requirements are met. If the necessary applications or information are not provided, CMS will terminate all payment to the provider, facility, or organization as of the date CMS issues notice that necessary applications or information have not been submitted.

(k) *Correction of errors.* CMS may review a past determination of provider-based status for a facility or organization or may review the status of a facility or organization (that is, whether the facility or organization is provider-based) if no determination regarding provider-based status has previously been made, if CMS believes that status may be inappropriate, based on the provisions of this section. If CMS determines that a previous determination was in error, and the entity should not be considered provider-based, CMS notifies the main provider. Treatment of the facility or organization as provider-based ceases with the first day of the next cost report period following notification of the redetermination, but not less than 6 months after the date of notification.

(1) *Status of Indian Health Service and Tribal facilities and organizations.* Facilities and organizations operated by the Indian Health Service or Tribes will be considered to be departments of hospitals operated by the Indian Health Service or Tribes if, on or before April 7, 2000, they furnished only services that were billed as if they had been furnished by a department of a hospital operated by the Indian Health Service or a Tribe and they are:

(1) Owned and operated by the Indian Health Service;

(2) Owned by the Tribe but leased from the Tribe by the IHS under the Indian Self-Determination Act (Pub. L. 93-638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes; or

(3) Owned by the Indian Health Service but leased and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93-638) in accordance

§ 413.70

42 CFR Ch. IV (10–1–01 Edition)

with applicable regulations and policies of the Indian Health Service in consultation with Tribes.

(m) *FOHCs and “look-alikes”*. A facility that has, since April 7, 1995, furnished only services that were billed as if they had been furnished by a department of a provider will continue to be treated, for purposes of this section, as a department of the provider without regard to whether it complies with the criteria for provider-based status in this section, if the facility—

(1) Received a grant on or before April 7, 2000 under section 330 of the Public Health Service Act and continues to receive funding under such a grant, or is receiving funding from a grant made on or before April 7, 2000 under section 330 of the Public Health Service Act under a contract with the recipient of such a grant, and continues to meet the requirements to receive a grant under section 330 of the Public Health Service Act; or

(2) Based on the recommendation of the Public Health Service, was determined by CMS on or before April 7, 2000 to meet the requirements for receiving a grant under section 330 of the Public Health Service Act, and continues to meet such requirements.

(n) *Effective date of provider-based status*. Provider-based status for a facility or organization is effective on the earliest date on which a request for provider-based status has been made, and all requirements of this part have been met.

[65 FR 18538, Apr. 7, 2000, as amended at 65 FR 58920, Oct. 3, 2000; 66 FR 1599, Jan. 9, 2001]

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH*.

(1) Payment for inpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:

(i) Lesser of cost or charges;

(ii) Ceilings on hospital operating costs; and

(iii) Reasonable compensation equivalent (RCE) limits for physicians services to providers.

(iv) The payment window provisions for preadmission services, specified in § 412.2(c)(5) of this subchapter and § 413.40(c)(2).

(2) Except as specified in paragraph (a)(3) of this section, payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients, and is subject to the Part A hospital deductible and coinsurance, as determined under subpart G of part 409 of this chapter.

(3) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services furnished by qualified nonphysician anesthesiologists employed by the CAH or obtained under arrangements, payment to the CAH for the costs of those services is made in accordance with § 412.113(c).

(b) *Payment for outpatient services furnished by CAH*.

(1) *General*.

(i) Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is the amount determined under paragraph (b)(2) of this section.

(ii) Except as specified in paragraph (b)(6) of this section, payment to a CAH for outpatient services does not include any costs of physician services or other professional services to CAH outpatients.

(2) *Reasonable costs for facility services*.

(i) Payment for outpatient services of a CAH is the reasonable costs of the CAH in providing CAH services to its outpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH outpatient services:

(A) Lesser of costs or charges;

(B) RCE limits;